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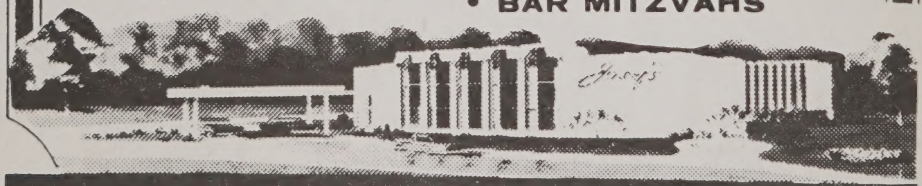

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PLACE: YANKEE PEDLAR INN
Holyoke, Mass.

DATE: Tuesday, September 25, 1979

BUSINESS MEETING: 6:00 P.M.

SOCIAL HOUR: 7:00 P.M.

DINNER: 7:30 P.M.

TOPIC: "THE IMPACT OF MEDICAL CARE AND MEDICAL COSTS ON THE LOCAL BUSINESS COMMUNITY."

SPEAKER:
Rand W. Gesing
Corporate Director of Management Development
Milton Bradley Company

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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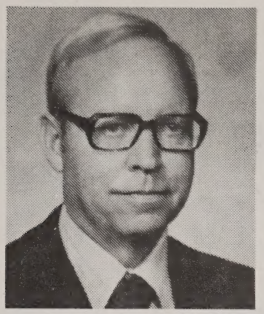


An Urgent Ethical Challenge

Medical ethics, like medicine itself, steadily gains new dimensions and presents us with new challenges. Today, no challenge is greater or timelier that the deceleration of health-care costs. And it's truly an ethical challenge.

Considerateness for the bills that patients pay is integral to respecting patients as human beings. And that respect is where ethics begins.

Valuable guidance in carrying out the cost ethic is provided by the report of the National Commission on the Cost of Medical Care that the AMA sponsored.

All of us, and each of us, must take it upon ourselves to activate the Commission recommendations that have been approved by the AMA House of Delegates. We must make them an organic part of the daily consciousness and conduct of our profession.

Let's consider three of the recommendations as examples.

First we must stimulte in our own ranks, in hospitals, and among our patients an effective realization of health-care costs and their impact on the system of care.

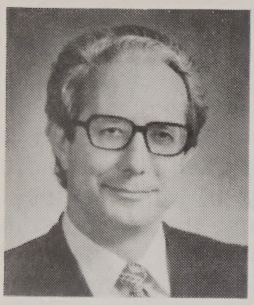
Second, we must urge intensified efforts to discipline those physicians who are found to be defrauding or abusing the health-care financing or delivery system. Also, we must enable more physicians to realize they have an ethical responsibility to report a colleague's misconduct. We cannot protect a wayward colleague without violating our own sworn duty to protect the patient.

Third, we must encourage intensified research toward a basic understanding of disease, and the most appropriate treatment thereof, within the context of today's urgent need for cost containment.

It must be stressed, however, that if we are to exert a maximum good influence on ethics and other growing issues, our Association must maximize its physician representation from all segments of our profession.

Every physician in this land has a membership in the problems that the Association copes with in his or her behalf. So let's have fuller membership in the Association and its solutions. □

HOYT D. GARDNER, M.D.
President, American Medical Association



PRESIDENT'S PAGE

Certificate Of Need Or Of Efficacy and Efficiency?

Vacation is a period when thoughts settle and reappear in a more organized format. Indeed having screened a multitude of published material regarding the cost of health (and in this field the inflation of words seems even more significant then the inflation of costs) it was easy to find, in different perspectives according to different authors, explanations for this phenomenon. Actually the factors more involved in this mechanism are two, global inflation and technological progress.

What were not so easy to find instead were solutions (even theoretical) to the problem. It seems that the most widely accepted strategies are two: the first involving a witch-hunt against excesses and abuses and the rationalization of hospital administrations; the second imposing restricting measures of economical nature which should have moderating effects on physician's fees and on patient's demands. Unfortunately the control of waste or methods of discouragement have their limitations and it seems to me difficult to expect from any of these measures anything more than a marginal effect in reducing health related expenses.

Now while inflation is part of a universal problem to be approached and possibly cured on a national level, it is with the cost of an ever more progressed medical technology that physicians and medical societies should cope with a sense of deep responsibility. It could be then that a more correct approach would be offered by individuals with a knowledge of health related problems totally different from that one of practicing or hospital based physicians. These individuals, true epidemiologists, should be observant of medical problems within a well determined social context. When controlled experimentations of new investigative techniques or therapeutic strategies prove that they are more beneficial than not to the patients, this proof should be provided to said epidemiologists who would then rate the efficacy of those new procedures. Practicing physicians are not new in accepting the validity of controlled experimentation pertaining to the efficacy of certain therapeutic modalities. How many of us, for instance, have ceased to use certain treatments once adopted universally and now considered almost useless like iron in mild anemias , ergotamine in every form of migraine or oral hypoglycemic drugs in many cases of diabetes of the adult age. Excellent diffusion of the practical results of controlled experimentation could in a sense not only save human lives but money as well. Laboratory examinations and diagnostic techniques, always more numerous and expensive, should undergo the same criterion of evaluation and if they fail to demonstrate the capability to modify the prognosis of a curable illness in a significant number of cases they should not be adopted.

Certificate of need then? No, certificate of efficacy instead which is a very different fact.

Once efficacy has been proven a second step is then necessary, the analysis of costs versus benefits: how to utilize the efficacious medical technique at a minimal cost, i.e. with the maximum efficiency. Even in this field the application of controlled experimentation will provide both health benefits for patients and significant savings of public money. Positive examples already available are represented by the reduction in the length of hospitalization after herniorraphies of myocardial infarctions or ambulatorial treatments of many illnesses previously routinely hospitalized (varicosities, certain mental illnesses, certain cases of tuberculosis). We are observing at present a conflict between different groups in the intent of containing the progress of health related expenses. Economists and politicians propose to act by organizing the health delivery at every level applying psychological and financial pressure on physicians and patients alike. Physicians and more generally those advocating the triumph of modern medicine and modern technology respond that if we wish that all patient benefit of medical progress it is necessary to pay for its high price.

The medical socieites must demonstrate that the problem of medical cost cannot be disconnected from the problem of medical efficacy. No treatment, no preventive measure, no laboratory examination should be adopted on large scale before we can demonstrate its positive effect to the patients and it is a controlled experimentation which should dictate this approach whenever possible from both ethical and practical points of view.

Once efficacy is established for a medical procedure then its cost should be evaluated and the more advantageous conditions for its application assessed. Should the procedure be done in a medical center or in a community hospital, or should it be done by a specialist or a general practitioner? On the bases of efficacy and efficiency it would be easier to establish priorities or needs for beds, technical devices and medical and paramedical personnel. For every illness which spontaneously heals completely or which evolves inexorably toward death without the possibility of modifying their course, medical and nursing personnel should limit their efforts to alleviating the suffering and providing comfort without the need for use for useless and costly procedures. We obviously must pay the price for modern medicine, but we should prove that this medicine is efficacious and capable to modify in a measurable way the natural course of an illness. How much money could be saved if a rule of this kind were adopted. □

FRANCO M. NAVAZIO, M.D.
President

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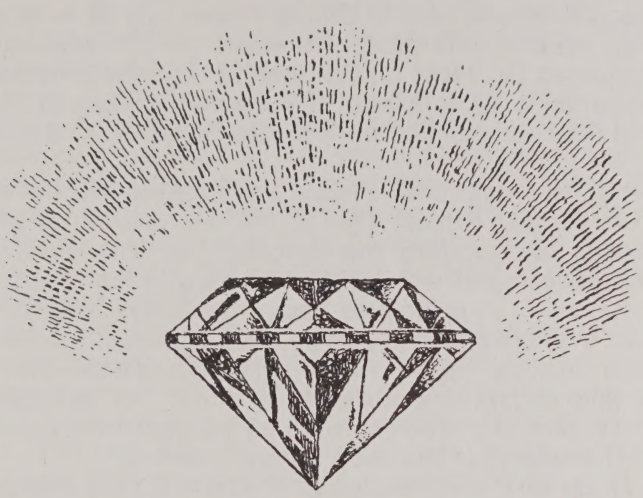

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Annual Meeting of the A.M.A.

The annual meeting of the House of Delegates of the American Medical Association was held in Chicago from July 22 to July 26, 1979. Two hundred seventy one delegates acted on 315 separate items of business, inducted Dr. Hoyt D. Gardner as the new president, elected Dr. Robert Hunter president-elect and elected 22 men to the Board of Trustees and the councils that will operate the A.M.A. during the next year.

The initial item before the House was a restatement of the A.M.A. Principles of Medical Ethics. This is the culmination of a three-year effort to clarify and update the language of this basic document, avoiding pronouncements which place the association in legal jeopardy. Although the new 7 principles lack the lofty language of their pre-decessor, they are presented as positive statements which challenge all physicans to live up to high moral standards. All delagates, component and constituent societies are not yet satisfied and the proposed principles are to be returned to the states for reconsideration and further discussion at the 1980 annual meeting.

Formulation of the Principles of Medical Ethics impinges on the relationship of the medical profession to chiropractic. No longer is it legally permitted for the society to proclaim principles which discriminate against chiropractors as an occupational group. To do so is to form a conspiracy. It is important to remember that there are no regulations which prevent a physician from being discriminating in his own professional relationships, something the new principles clearly encourage. Although some organizations would like to have the A.M.A. describe appropriate individual behavior in relationships with chiropractors, we should not really expect others to make our ethical decisions for us.

The discussions regarding national health insurance were more succinct than expected. Six months ago the House of Delegates informed the Board of Trustees that it did not like what the Trustees had been doing in the field of national health legislation. The Board was instructed to take a new direction, emphasizing simplicity, private catastrophic insurance coverage and administration on the state level. Compulsion was to be avoided. A bill was to be introduced only if

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necessary to prevent violation of these principles. The Board of Trustees accepted the rebuke administered by the House with good grace. Frequent detailed reports have kept delegates and state officers appraised of every action by the Board of Trustees. The House of Delegates (by a 2 to 1 majority) accepted the Board's reports and rejected a series of more restrictive recommendations. The "sense of the House" was loud and clear.

The most important actions taken by this House were administrative. After prolonged and impassioned debate, the A.M.A. withdrew its support of LCCME, the present committee supervising the accreditation of continuing medical education. In its place, the A.M.A. will form a new body with representatives from many of these same organizations, but with greater A.M.A. control. Since the A.M.A. has been paying the bills for the accrediting body, it is probable that this reorganization will proceed.

Even more important to the future of the Association were the discussions regarding membership. It is well known that A.M.A. members now represent only 48 percent of the 452,000 physicians in the U.S. In fact, there are only 150,000 full dues-paying physicians in the Association. The rest are getting a free ride in the educational and representational activities of the A.M.A. which affect all physicians. If the freeloaders can be brought into the Association, the dues-paying members would get a better financial break. The House of Delegates voted to strive to become the umbrella organization for all physicians' organizations. The Council on Long Range Planning and Development will explore the possibility that membership in the A.M.A. shall consist of those medical associations who are now considered constituent or component medical associations. These organizations will fund the A.M.A. budget and individual doctors will pay dues through these organizations. This means that individual doctors will not pay A.M.A. dues, but dues to state and recognized specialty societies will increase proportionately. It will take a year or more to work out the details of this plan and another year to make the necessary by-law changes. The immediate membership situation is so critical that the House was asked to permit direct membership recruitment, but this was denied except on a pilot basis.

Many other problems were discussed, from the indications for aortocoronary bypass through physician participation in HSAs, to the plight of the "boat people." Programs were started, propelled or curtailed on the best judgment of serious-minded physicians. But it will avail us little unless the membership problem can be solved. □

GARRY deN HOUGH, III, M.D.
Alternate Delegate

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REPORT FROM CHICAGO

At the request of President Rodkey, Dr. Sidney A. Levine, Chairman of the Massachusetts Medical Society's **Committee on Medical Service,** and I, a member of the committee, attended the annual meeting of the American Medical Association in Chicago, July 22-26, 1979, charged with summarizing and reporting to the Council of the MMS those matters of concern to the AMA's **Council on Medical Service** which may have an impact in Massachusetts. Following is the draft of my report to Dr. Levine, from which he will formulate the combined report to the Council, and which Mrs. Purdy requested my permission to publish to our members in Hampden District.

AMA ACTIVITIES IN HEALTH PLANNING

Council on Medical Services Report E presented on update on AMA activities in health planning, with special emphasis on the AMA-sponsored 23 amendments to the pending renewal of the health planning authority of Public Law 93-641, the National Health Planning and Resources Development Act of 1974. The report reviews the status of health planning renewal legislative bills which were filed through May in the Senate and House, and notes that new HEW regulations on appropriateness review, governing body composition, review of federal assistance funds to the health service area, and National Health Goals and Sub-Goals, all of which were due to be published by now, have been delayed until the health planning authority under PL 93-641 has been renewed.

CMS Report I brought Report E up to date and presented material on the June 1979 Midwest Regional Health Planning Workshop, conducted by the AMA for state and county medical societies and health planning agency personnel of the states of Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin (HEW Region V). The Midwest workshop is the second in a series of such workshops being conducted around the nation, designed to expand and enhance communication between medicine and the network of health planning agencies at the state and local level, and to encourage more effective physician participation in health planning. The third such regional workshop is tentatively scheduled for the Northeast in October or November 1979.

The House of Delegates of the AMA accepted CMS Reports E and I for filing and approved a resolution requesting the AMA to work for an increased role in health planning for the medical society and physicians at the local level, and a diminished role for federal legislative and bureaucratic bodies.

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PHYSICIAN EXTENDER SUPERVISION

CMS Report F on Physician Extender Supervision was discussed, amended, and adopted as amended by the House of Delegates. The Report as amended clearly states that it is AMA policy that the personal presence or participation by the supervising physician in the physician extender's activities where the services are rendered should be the standard care in the usual practice settings. In unusual practice settings exceptions to this standard of care should be determined, and a specific waiver to this standard may be granted, by the state medical board on an individual, case-by-case basis.

The CMS was advised to continue to study and reevaluate its position on physician extender programs through the adoption by the House of Delegates of the New Jersey delegation's Resolution 9 mandating a follow-up report on this subject at the December 1979 meeting.

PHYSICIAN-DIRECTED RURAL HEALTH CLINICS

In a related report, CMS Report J examined Rural Health Clinics with particular regard to mechanisms which operate to maintain quality medical care and mechanisms for reimbursement of physicians employed by such clinics. The report recommended that the AMA continue to work toward insuring the quality of care provided in rural health clinics through all appropriate means and adopt a policy of encouraging experimentation with different physician reimbursement methods in such clinics, including fee-for-service and reimbursement on the basis of usual and customary or reasonable charges where applicable.

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The House of Delegates amended the report to apply to federally-funded clinics only, and adopted it as amended, with instruction to the CMS to continue monitoring quality assurance and reimbursement procedures in federally funded health clinics, and to report back at the 1980 annual meeting.

REIMBURSEMENT UNDER FEDERALLY FINANCED PROGRAMS: STATUS REPORT

CMS Report G presented an update on the Council's effort to obtain fair reimbursement of hospital costs under federal programs, with special reference to such factors as hospital medical and paramedical education programs. The report pledged that the CMS will continue to study and monitor this problem and report to the House of Delegates when there is any significant change or if the CMS develops specific recommendations for House consideration. The report was accepted and filed by the House of Delegates without discussion.

RELATIONSHIP OF HOSPITAL COSTS AND HOSPITAL CHARGES

CMS Report C. was filed by the House of Delegates as informational. This report indicated only that the study, directed by the House in December 1978, on the proper relationship of hospital charges to hospital costs, was as yet incomplete and inconclusive and would be carried forward for final report in December 1979.

INFORMATION ON ALTERNATIVE HEALTH CARE BENEFITS

CMS Report A concerned the progress made by the Council on Medical Service in the implementation of the intent of Recommendation 6 of the National Commission on the Cost of Medical Care, approved by the House of Delegates on year earlier, calling for the provision to consumers of clear, concise and comparable information on alternative health care benefit plans offered by insurors, including information on benefits and exclusions and the premium benefit ratio.

The Council determined that the use by all states of the model legislation and regulations promulgated by the National Association of Insurance Commissioners (NAIC) and endorsed by the Health Insurance Association of America, relating to (1) clarity and readability of contract language, (2) uniform policy provisions, and (3) minimum standards for

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health insurance, would to a significant degree accomplish the intent of the House. Sixteen states were found to qualify at present in all three respects and ten more had legislation to accomplish one or two of these goals. Report A recommended that the AMA work through its consituent state associations to encourage the adoption by all states of the NAIC model legislation.

The House of Delegates amended the report to endorse AMA efforts to secure the consideration by the states of the "outline of coverage" requirements in the NAIC model legislation bill, and the entire bill on clarity of contract language, but specifically disclaimed any endorsement of the NAIC model legislation in its entirety. The House then adopted the report as amended, with the addition that the CMS continue to report to the House on this matter as appropriate.

PATIENTS ACCESS TO INFORMATION CONTAINED IN MEDICAL RECORDS

CMS Report B is an informational progress report on the implementation of the House of Delegate's vote in December 1978 calling for CMS to assess the impact of state legislation allowing patients access to their medical records on such factors as the incidence of professional liability litigation, patient care, and physician-patient relationships. The Council reported no adverse effect as yet in the 14 states with such statutes in force, and some suggestion of positive effect, but indicates that it is too early to draw conclusions, since half of those statutes in force were adopted in 1977 or 1978. Continuing assessment and a follow-up report is planned for December 1979. The House of Delegates accepted the report for filing

STATUS REPORT ON HMOs

CMS repord D constitutes the current installment of an on-going study report and monitor update on the status of the Health Maintenance Organization (HMO) program, a study first commissioned by the House of Delegates in 1978. Report D was accepted by the House for filing. Some of the highlights of the report follow.

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and Blue Shield Associations operate or provide services to 65 prepaid health plans. Twenty-five different indemnity insurance companies operate or provide services to an additional 50 prepaid plans. Several major corporations, including DuPont, Deere, Sears, IBM, GM, Chrysler and Ford are in the formative states of HMO involvement or are already offering the HMO option to their employees.

HEW grants totaling almost $17 million were awarded to 93 different plans during fiscal year 1978, bringing total grants awarded since program inception to $92.5 million. An increase in federal appropriations for HMO development from $32 million in FY'79 to $74 million for FY '80 has been requested from the Congress.

The Council on Medical Service has chosen 15 HMOs across the country to study in depth, including site visits, for report to the House at the December 1979 meeting, together with any implications for future AMA policy.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS: STATUS REPORT

CMS Report H constitutes the current installment of an ongoing study report and monitor update on the status of the Professional Standards Review Organizations (PSRO) program, a study first commissioned by the House of Delegates in 1972. Some of the highlights of Report H follow.

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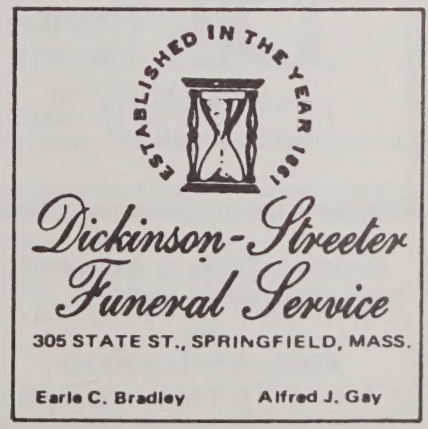

As of April, 1979 HEW had approved 188 conditional PSROs and three planning PSROs out of a total of 195 designated PSRO areas. Federal funding in FY 1979 was reduced by approximately 30% to $150 million and now averages $8.70 per review. No further financial cutbacks are projected for FY 1980 at this time but the limits of funding are forcing HEW to eliminate non-performing PSROs, to consider mergers of small PSROs, and to stress focused review rather than review of all covered admissions. Less than one-third of the PSROs are expected to receive funds for long-term care review or ambulatory care review in FY 1980.

Controversial developments in the PSRO program include new rules by HEW with respect to provider sanctions for violation of PSRO obligations relating to necessity and quality of health care services, new rules for disclosure of PSRO information to others with a "need to know", and new rules providing for appeal of PSRO medical necessity and level-of-care determinations. Needed modifications to these rules have been brought to the attention of HEW and appropriate amendments to the PSRO law were introduced in Congress by the AMA.

Of great concern to the Council of Medical Service is the pending HEW proposal to allow for the collection and processing of the Uniform Hospital Discharge Data Set (UHDDS) through fiscal intermediaries and agents rather than through the PSRO. This proposal was strongly opposed by the AMA following a vote of strong disapproval by the House of Delegates in December '78, opposing collection of any UHDDS data by fiscal intermediaries other than PSROs.

Also strongly opposed by AMA is the suggestion that HEW might pursue a long-range plan for collection of UHDDS material on non-federal beneficiaries. The AMA has proposed eighteen amendments in all to the PSRO provisions of the Social Security Act for submission to Congress and has drafted legislation which would make PSRO data exempt from disclosure under the Freedom of Information Act.

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In discussion of CMS Report H some physicians expressed concern with increasing emphasis by PSRO programs on cost containment rather than quality assurance. The reference committee recommended continuing support of PSRO as long as it continues to be a "professionally directed effort to ensure that care provided to patients is of high quality, appropriate duration, and rendered in an appropriate setting at reasonable cost", reserving reconsideration of support if cost containment becomes the predominant program objective.

The recommendation of the reference committee to adopt CMS Report H, generally favorable to the PSRO program, was approved by the House of Delegates in lieu of two negative resolutions on PSROs and PSRO budgets submitted to the House by the Ohio and Georgia delegations.

CONCLUSION

It should be stressed that this summary deals only with those eight reports presented to the House of Delegates by AMA's Council on Medical Service, and the House's action thereon. During the meeting the House also received and acted on an additional 60 reports from the Board of Trustees, four other Councils and several ad hoc committees, at least 176 resolutions and substitute resolutions from individual members, delegations, specialty societies & reference committees, and a report of the Nominating Committee preliminary to annual elections.

The suprising depth and range of reporting, and the staggering volume of material presented to the delegates, cannot fail to impress the observer and to leave a lasting impression that the AMA is a uniquely strong and effective democratic organization absolutely devoted to the welfare of those people whom we call our patients and of their physicians.

The state Committee on Medical Service cannot help but benefit from this exposure of its membership to national data and opinion. □

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La Guerre Est Fini

At its last meeting, the Executive Committee of the Medical Staff of the Baystate Medical Center unanimously rejected the A.D. Little Company's recommendations designed to make the merger of the Springfield and Wesson Memorial hospitals work.

Rightly so, for the recommendation included nothing less than transferring all trauma, vascular, thoracic and major neurosurgery, as well as urology, to the Springfield Campus. General surgery was to be manintained, and dental, ear, nose, throat, eye, and plastic surgery would have been transferred to the Wesson Memorial. The reasoning was that this arrangement would eliminate the duplication of equipment, and more importantly, it would create a semblance of the merger actually working.

It is easy to see how disruptive any attempt at implementation would be. The Wesson Emergency Ward handles 60% of all emergencies and an even larger proportion of trauma. The Wesson Operating Room handles about 75% of orthopedics, 30% of neurosurgery, 25% of chest and vascular surgery, and does most of the plastic and dental work still being done at the institution. The Emergency Ward, Operating Suite, X-ray and Laboratory facilities of Springfield Hospital would be overwhelmed. The present 6-8 week waiting period for elective admissions would be pushed out much further. A rather expensive building program would be mandated. Any savings would be illusory because changing the case mix would not change the patient mix significantly. Elderly people, patients with coronary and other heart disease are equally prone to have hernias, gall bladder disease, bleeding ulcers. Many of these patients would require the same monitoring as do candidates for coronary bypass surgery. The need for an active, well-equipped Intensive Care unit and Coronary Unit would not be obviated. Against any meager savings, the dislocation would be enormous.

Yet, it would be unfair to saddle A.D. Little with all the blame. After all, they were asked to make an unworkable situation work. Their failure to square the circle does not reflect on them, only on those who asked them to try. Their representative made it clear that he wished he was called in before the merger occurred.

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How true... The history of the merger until now is rich in wasted opportunities, discord and a hemorrhage of physicians and patients to other hospitals. Why did this have to be so? Because the merger was rammed through without forethought or foresight, without consulting those whose professional lives were to be affected. The respective misssions of the two hospitals were not defined. No groups or individuals could give any thought to the future or do their bargaining and make accomodations. The Springfield Campus was already organized along more hierarchical lines and had the initial advantage. Soon, Wesson physicians found that they had to fight for their rights, for equipment to take care of their patients, and fight the demoralization of ancillary personnel on their campus. It is ironical that of the two vectors that overwhelmingly decided for the merger, one never materialized. This was feared classification of emergency rooms. The common purchase of the CAT scanner rather characteristically worked to the detriment of Wesson Memorial patients. They are the only group not reimbursed by third parties for the ambulance trip to the Springfield Hospital and back. The bill, $110. out of pocket.

I am proud to say that even though by material indices we slipped behind most other hospitals, we hustled, improvised, begged and borrowed, but maintained our record of excellence and our outcomes speak for themselves.

We have now come full circle. Reality will have to be faced by those who wanted bigness for bigness' sake and control for control's sake. The two institutions will have to live out their life-span, be updated where necessary and made hospitable to those who render medical care to the community--the private practitioners. Funds, heretofore, squandered on fancy offices, more administrations, and the hiring of full-time physicians will have to be spent on nursing staff, equipment, and other patient-related items. To run efficiently, both campuses will have to be given a reasonable measure of autonomy. Morale will have to be rebuilt, especially on the Wesson side. Only thus will we again attract physicians and their patients. Only thus will we acquire the financial wherewithal to build a new hospital worthy to be called a medical center that will make the merger a reality. This will not come overnight, but has to come. Meanwhile, it will allow a respite during which the two sides can negotiate, get acquainted, and forget the hostilities engendered by the past three years.

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There are lessons to be learned. The medical staff will have to shed its apathy. We should never again allow our responsibilities to our patients take the back seat to the ambitions and whims of others, less knowledgeable than we are. The Trustees of the institution will have to learn from this expensive fiasco. They must remember that physicians are customers of the institution and not junior executives who can be made to conform or be fired. They must also remember that this important difference not withstanding the principles of good management still apply. If a hospital is to prosper in the present climate, it must be managed as an enterprise aqnd not as a monument to the greater glory of the Board. To this end, the medical staff and especially the younger private practitioners who will see the fruits of the merger, should be given adequate representation on the Board of Trustees.

Finally, it would be a pity if some of the better recommendations of A.D. Little went unheeded. The tensions between the private and hired staff must be defused and the place of the private staff be made secure. The statistics of over-representation of specialists in the area cannot be ignored. For the institution in its present state to have any free-standing training programs is expensive, pretentious, and unnecessary. Busy practitioners should not have to supervise trainees with no previous experience, who need constant attention. The result can only be unfair to both trainees and patients. We would be ideally suited, however, to become a ''finishing school'' where senior residents from academic programs would come to get ''real life'' experience before starting their own practices. Primary care training should be emphasized in keeping with the needs of the community.

The lessons are many. I trust that we will be able to learn and prepare for the future in harmony. □

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In Memoriam

HARLAN W. ANGIER, M.D.

Dr. Harlan W. Angier of Brookfield, Massachusetts, died on July 6, 1979 at Mary Lane Hospital.

Born in Southboro, he lived in Ware and Brookfield and practiced there until his retirement.

Dr. Angier was a consultant for both Mary Lane Hospital in Ware and Wing Memorial Hospital in Palmer. His medical degree was received from Tufts University Medical School.

In 1969 he received his 50 year membership from the Massachusetts Medical Society. He was a member of the American Medical Association, Hampden District Medical Society, Springfield Academy of Medicine, and the Grand Lodge of Masons and the Brookfield Rotary Club.

Sympathy is extended to his family and associates. □

In Memoriam

ROGER D. HEBERT, M.D.

Dr. Roger D. Hebert of Longmeadow died on June 26, 1979 in Baystate Medical Center.

He lived most of his life in Chicopee although he was born in Holyoke, Since 1968 Dr. Hebert was associated with the Wesson Emergency Associates at the Wesson Memorial Hospital.

Dr. Hebert was an Army Air Force veteran of World War II.

He was graduated from Loyola University and earned his medical degree at Laval University Faculty of Medicine and studied Surgery at Harvard University.

He was a member of the American Medical Association, Massachusetts Medical Society, Hampden District Medical Society and the Springfield Country Club.

To his many friends and Colleagues sympathy is extended. □

In Memoriam

ARTHUR J. LOGIE, M.D.

Dr. Arthur J. Logie of Tavares, Florida, formerly of Westfield, died July 26, 1979 in Florida.

Born in New Haven he attended Yale University and received his medical degree from Temple University School of Medicine.

He was Chief of Staff at Noble Hospital from 1941-1946 and again from 1958-1960.

Dr. Logie was a General Practitioner in Chester and in 1922 became associated with Dr. Archiblad J. Douglas in Westfield where he practiced until he retired. He was Medical Examiner of the 4th Hampden District and was a medical examiner for the Federal Aviation Administration. He was a sports fan and contributed much enthusiasm for the football team at Westfield High School.

Deepest sympathy is extended to his family and many friends. □

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VNA Introduces Hospice-Related Voluntary Care Giver Program

The following resolution was adopted by the House of Delegates at the Annual Convention in St. Louis in June, 1978:

RESOLVED: That the American Medical Association approve the hospice concept to enable the terminally ill to die in surroundings more homelike and congenial than the usual hospital environment; and be it further RESOLVED, that this action be widely publicized to encourage extension of this specialized approach for the provision of terminal care.

The above resolution is pertinent to what is happening in the VNA today. The Visiting Nurse Association of Springfield has named Edith Dorang as its Coordinator of Voluntary Care Givers.

Since November 1978 the Visiting Nurse Association of Springfield has been participating in a hospice-related, team approach when working with its patients and families experiencing a terminal illness situation. The program has been titled Voluntary Care Giver (VCG). It was conceptualized by a student intern from the Rehabilitation Department of Springfield College. This individual not only lay the groundwork for the program but also participated as the VCG example for the Springfield VNA team and designed an educational slide presentation regarding the experience.

In April 1979 the agency endorsed a temporary position known as Program Planner to continue working on the Voluntary Care Giver approach. In May 1979 Faith United Church of Springfield contributed money from its Hope Church fund to be used as "seed money" to help support this four-month, interim position. A grant from the Dexter Fund administered by Bay Bank Valley was awarded in July 1979 to the Visiting Nurse Association of Springfield to underwrite the salary and expenses of a coordinator who will continue efforts to establish a hospice-related voluntary care giver program within the agency.

If the reader has any questions about this position or possibilities for his or her use of it in the future, contact Edith at the VNA number, 781-5070. □

AUXILIARY NEWS

On Wednesday, September 26th, at 10:45 a.m. the Auxiliary will hold the Fall meeting and luncheon. This will be the first meeting of a busy and productive year of activites under the capable leadership of the new president, Jean Medrek.

The meeting will be held in the Portrait Room at the Springfield Science Museum. The future of Health Hall will be the topic of discussion with Helen Burzynski, Chairman of the Allied Health Div. at S.T.C.C., and Charles Roberts, Development Director for the Museum, as speakers. The meeting will be followed by wine and cheese, and a

"Heart Room" presentation. Luncheon at 1:15 p.m. is at Two Mattoon. Co-Chairwomen are Diana Abbasy and Joan Guardione. There will be a baby sitter for walking children. Please indicate if you need her services. Ample parking is available at the Quadrangle parking area, or in the parking lot across the street from the Springfield Library.

Wednesday, October 10th is the date for the trip to Boston's Quincy Market. Departure time from the Longmeadow Municipal parking lot is scheduled for 8:30 a.m. The bus will return to Longmeadow at 5:15 p.m. This is a fund-raiser for Health Hall, and the price of the trip is $10.00..

Martha Giguere is in charge of the Welcome Wagon this year, assisted by Lois Peck for Wilbraham, Evelyn Anton, Palmer and Belchertown; Mary Hojnoski, Springfield and Chicopee; Betty Lynch, North Amherst, South Hadley and Holyoke; and Luciana Navazio (assisted by Jay Rosenthal), Longmeadow. If you know of any physician's family new to our area, please contact one of the above chairmen. □

MARION L. RILEY

The Four Seasons

Antonio Vivaldi, an obscure priest, in
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upon the shoulders of others and improve
their styles.

Vivaldi wrote a violin concerto - entitled
Four Seasons;
Spring, Summer, Autumn and Winter
The beauty of each theme, musically expressed,
is a gem in all of tonal compositions.
It reminds me of our own life-span, the
intricate time-piece, that does not falter.

Spring, the span from birth to tribulations;
Summer, the interlude of youth, passion and vigor.
Autumn, an oasis, to harvest upon our needs and
hitherto attainment;
The Winter of our life, a period of reflection, what was,
what is, and what we now are.
Be not sad, for if you have but touched a single
soul and healed a festered wound.
you have done much, be content..

SETRAG A. ZACARIAN, M.D.

United Way

The response of area physicians to the 1978 United Way Fund drive reflected a sensitive awareness of community responsibility and resulted in a surge of previously unmatched generosity. The results were most commendable, coming at a time when the "doctor image" needs reburnishing in the public's eye.

We cannot afford to rest on these laurels. As another United Way appeal approaches, we must renew our faith in and committment to community services the United Way supports, recognizing the inflationary trend by trying to increase our participation in amounts and numbers.

Remember, also, if you will, that the volunteers who give so freely of time and effort to the campaign are working in the same harness and pulling for community improvement. Please keep this in mind as they attempt to enlist your support during those inconvenient hours of work and pleasure. □

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in brief

The AMA will construct a 12-story building in Washington, D.C., just south of Thomas Circle at Vermont, Land 14th Streets. The AMA Washington Office will occupy one floor. The other floors will be rented. In announcing the building plans, AMA EVP James H. Sammons, MD, invited other medically oriented organizations to share the facility with the expectation that the building would become a focal point for organized medicine in the capital. The headquarters of the AMA will remain in Chicago.

The third edition of the Planning Guide for Physicians' Medical Facilities has been published by the AMA Dept. of Practice Managemnt. The book features eight pages of floor plans for the practitioner planning to build or remodel an office, as well as several construction suggestions. The Planning Guide is $3 a copy. To order write AMA, P.O. Box 821, Monroe, Wis. 53566.

A program to oversee the activites of regulatory agencies is long overdue, the AMA told Congress in a letter supporting the Sunset Act of 1979. The bill would make federal programs and funding subject to mandatory review by Congress at least once every ten years. In a letter to the chairman of the House Sub-committee on the Legislative Process, the AMA said the "sunset" concept is a needed step toward stemming the "tremendous proliferation of regulatory activities in the Executive Branch of the federal government." The AMA urged that the inflationary impact of regulations be evaluated and that the least inflationary alternative be selected whenever possible.

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